PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

OVERPAYMENT NOTIFICATION FORM – GENERAL INSTRUCTIONS FOR PROVIDERS

Use this optional form to return an overpayment or respond to a request from Premera Blue Cross Blue Shield of Alaska Follow the steps below for the fastest handling of your overpayment.

Please don't use this form for corrected claims. To submit a corrected claim, complete the Corrected Claim Cover Sheet and submit it with any required documentation. If your corrected claim results in an overpayment in the amount of $50 or more, please note your options below:

1. Mark the appropriate box on the form. Your options include:

    a. Check attached:
    Submit a check along with the completed overpayment notification form and mail to:

    Premera Blue Cross Blue Shield of Alaska
    PO Box 745020
    Los Angeles, CA 90074-5020

    b. Request a voucher deduction/offset:
    The overpayment amount will be offset against future payments (voucher deducted). If a letter is needed please see the next option.

    c. You'll receive an overpayment refund request letter for refunds of $50 or more. Once you receive the letter, you can send in your payment. Attach your payment to the refund request letter for faster processing.
    NOTE: If the total overpayment amount isn't refunded within 60 days from your initial notice, the amount will be offset against future payments.

2. Attach any required documentation.

Tips for faster processing of your request:

- We won't send you a refund request letter for refunds less than $50. If you need documentation, please use our Standard Provider Letter For Refunds Less Than $50 PBCAK
- There's no need to submit a duplicate notification to us via fax if you are mailing a check to us.
- An explanation of benefits (EOB) from the other insurance carrier is required if coordination of benefits is the reason for overpayment.

Overpayment Notification Form

PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

Use this form when notifying Premera Blue Cross Blue Shield of Alaska of an overpayment.
All areas with an asterisk (*) must be filled out.

*Today's date: _____

- ☐ Check attached
- ☐ Check this box to request a voucher deduction/offset
- ☐ Please send a refund request letter (Note: If the total overpayment amount hasn't been refunded within 60 days from your initial notice, the amount will be offset against future payments.)

➤ Claim/Patient Information ➤

*Provider name: _____

*Claim number: _____

Subscriber name: _____

*Patient name: _____
Complete if different from subscriber

*Subscriber number: _____
Include plan prefix

Patient DOB: _____

*Date of service: _____

*Claim total charge: $ _____

Overpayment amount: $ _____

Please note that we do not request refunds or voucher deduct for overpayments under $50. These can be submitted voluntarily.**

Who should we call if we have a question?

*Contact name: _____

*Contact number: _____

Provider mailing address

Attention: _____

*Provider Group Name: _____

*Address: _____

*City, state ZIP: _____

Questions: Call Calypso at 800-364-2991.

Fax this form to 425-918-4722.

Thank you!

*Reason for Overpayment

☐ Primary Insurance Information (Coordination of Benefits) Required: EOB from other insurance plan

Name of other insurance: _____

Insurance address (include ZIP code): _____

Subscriber name: _____

Phone #: _____ Policy # : _____ Group #: _____

☐ Duplicate payment/other claim number: _____

☐ Incorrect patient: _____

☐ Services not rendered: _____

☐ Subrogation: _____

☐ Other: _____

**We reserve the right to request a refund of multiple claims that individually are less than $50.